

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dinesh Shah a prisoner at HMP Sudbury on 7 May 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Dinesh Shah died on 7 May 2016, of bronchopneumonia related to his COPD (Chronic Obstructive Pulmonary Disease) at HMP Sudbury. Mr Shah was 66 years old. I offer my condolences to Mr Shah's family and friends.

Mr Shah had very complicated health needs, with a variety of serious conditions. The investigation found that he was generally well cared for during his time in various prison establishments, including Sudbury.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2017

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Summary

Events

1. On 16 November 1982 Mr Shah was convicted of murder and sentenced to life imprisonment. He was released on licence on 6 April 2005, but his licence was revoked in July 2007. Mr Shah had left the country but he was returned to prison on 19 June 2009, and sent to HMP Leicester. He was transferred to HMP Sudbury from HMP Stocken on 3 February 2015, with a history of heart failure, COPD, asthma and diabetes.
2. Healthcare staff at Sudbury noted Mr Shah had COPD, ischaemic heart disease and diabetes and that a team at a hospital managed his respiratory and cardiac issues. There was some delay in transferring these responsibilities to a closer hospital.
3. On 6 January 2016, almost a year later, after another Trust had assumed responsibility for Mr Shah, a nurse assessed him and arranged for him to have overnight oxygen therapy. Around this time, his health also started generally to deteriorate. He felt weak and needed assistance with daily living tasks and was admitted to hospital in April 2016 for five days, with an exacerbation of his COPD.
4. Staff closely monitored him when he returned to prison but, when it became apparent that he was forgetting to take his medication and he slowly became less responsive, he was readmitted to hospital on 3 May 2016. He did not recover and died on 7 May at 8.14am.

Findings

5. The clinical reviewer found that the care Mr Shah received at HMP Sudbury was equivalent to that he could have expected to receive in the community. The clinical reviewer noted there was a delay in arranging an oxygen assessment, but this was partly due to Sudbury's reasonable request for specialists at Glenfield Hospital to retain responsibility for Mr Shah's care. It did not, however, have an impact on Mr Shah's death.
6. The investigation found that staff at HMP Sudbury did not assess the impact of Mr Shah's death on prisoners subject to suicide and self harm procedures (ACCT). They did not feel it was necessary because they did not think any prisoners subject to ACCT knew Mr Shah. This was an unwarranted assumption, inconsistent with HMPPS policy. Mr Shah's death could have acted as a negative trigger for those who were emotionally vulnerable.

Recommendation

- The Governor should ensure that following a death in custody, staff review all prisoners on an ACCT.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Shah's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Shah's clinical care at the prison.
10. The investigation was suspended for nine months, as there was no cause of death. We regret the subsequent delay in issuing the report.
11. We informed HM Coroner for Derby and South Derbyshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Shah's nephew to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He wanted to know if Mr Shah's death had been from natural causes.
13. Mr Shah's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended in places accordingly.

Background Information

HMP Sudbury

15. HMP Sudbury is an open prison with an operational capacity of 581 adult men. Derbyshire Health United provide healthcare services during the day on weekdays and in the mornings at weekends. There are specialist clinics to treat substance misuse. A number of prisoners are released each day on licence to help with their resettlement. In April 2016, Care UK were awarded the contract.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Sudbury was in November 2013. Inspectors reported that very low staffing levels created feelings of insecurity for the prisoners and the relationship between staff and prisoners was poor. Prisoners were unhappy about healthcare provision, which inspectors considered was partly due to more restrictive prescribing practices. Overall, inspectors considered that health services had improved but staffing shortages had had an adverse impact on service delivery.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that Sudbury was a well-run prison providing a positive environment for most prisoners even though it was an old building with a limited budget and low staff numbers. Healthcare was described as patchy with some long waiting lists and the use of agency staff compromising provision.

Previous deaths at HMP Sudbury

18. Mr Shah's death is the first from natural causes at Sudbury since 2013.

Key Events

19. On 16 November 1982 Mr Shah was convicted of murder and sentenced to life imprisonment. He was released on licence on 6 April 2005, but his licence was revoked in July 2007. Mr Shah left the country but the authorities eventually returned him to prison on 19 June 2009, and sent him to HMP Leicester. He was transferred to HMP Sudbury, after a period in HMP Stocken, on 3 February 2015 with a history of heart failure, COPD, asthma and diabetes.
20. On 4 February 2015, a nurse completed Mr Shah's first night screening. He was very underweight at 44kg (his ideal weight was 72.13kg), smoked cigarettes (but was not interested in stopping), had COPD (chronic obstructive pulmonary disease – lung disease), ischaemic heart disease, and diabetes. A prison GP saw him the next day and noted he was under the care of a cardiologist and a community respiratory team at a hospital.
21. The GP thought it would be beneficial for Mr Shah to continue to be cared for by the existing team of specialists at the hospital for his cardiac and respiratory issues. (On 19 February, the GP recorded he had agreed this with them, at least until Mr Shah's conditions stabilised.)
22. On 9 February, a nurse at the hospital's community Long Term Conditions Team, referred Mr Shah for a home oxygen assessment (she did not actually see him). On 18 March another nurse, also of the community LTCT, recorded that she had discharged Mr Shah from their caseload as after a conversation with the prison (presumably his previous prison HMP Stocken) she discovered that he no longer was in their area. Although this was recorded on SystmOne (an electronic medical record), it is not clear whether anyone at Sudbury was alerted to the fact, or that they were aware of it.
23. On 5 May, a nurse in the prison noted that the hospital had phoned her to say they had also removed Mr Shah from their respiratory clinic list as he no longer lived in their area. He had turned up for an appointment there the week before, so they had seen him anyway but would not be doing so again. They had tested a sputum sample and it showed the presence of pseudomonas (a type of bacteria) which was common for COPD patients. They recommended that as long as he remained symptom free it was not necessary to treat him, but if he developed any symptoms then ciprofloxacin should be prescribed. Again, it is not clear what prison healthcare staff did immediately about his discharge from the team's care.
24. On 29 June, a nurse from the LTCT recorded that someone from the prison's healthcare unit had asked her if Mr Shah could have an oxygen assessment at the hospital as all his consultant care was there. She said she would request it but that the LTCT nurses could not see him because he did not have a GP in the right area. On 6 August, a nurse recorded that the hospital would not see him because of the area issue (they confirmed this in a letter received by a nurse on 11 September). After a conversation with the Head of Healthcare at Sudbury Prison, a nurse wrote to a hospital asking if they would see him or pass the referral to someone who could.

25. On 6 January 2016, a nurse from the Derbyshire Home Oxygen Assessment Service saw Mr Shah and arranged for him to have oxygen overnight. She talked him through what was involved and the risks of smoking around the equipment.
26. From the beginning of 2016 onwards, Mr Shah's health generally started to decline. Apart from COPD and asthma, he also had ischaemic heart disease, atrial fibrillation, angina, high blood pressure, coronary artery disease, ischaemic cardiomyopathy (diseases of the heart muscle), severe left ventricular systolic dysfunction, an aortic aneurysm, diabetes and chronic kidney disease, all of which had been managed by the various prisons in which he had been held.
27. On 2 March 2016, Mr Shah told a social worker that he felt weaker and had had to have assistance to make his bed and fetch meals. She assessed him, discussed his case with healthcare staff and arranged for a 'buddy' referral to help him with daily living tasks. She also made a wheelchair referral (he already had an electric scooter) and a few days later a prison GP arranged for a dementia assessment, as she noted Mr Shah had become more argumentative. It is not clear if this specific assessment was done, but the social worker and a nurse visited him on 13 April and established that Mr Shah was able to understand the choices about being resuscitated.
28. On 7 March, Mr Shah saw a prison GP as he felt particularly wheezy. The GP diagnosed a chest infection and prescribed antibiotics.
29. During the first two weeks of April, healthcare staff visited Mr Shah frequently on the wing, monitoring his oxygen saturation levels and his general condition which slowly worsened. On 15 April, a nurse Johnson admitted him to hospital to stabilise, as he had an exacerbation of COPD. He stayed in hospital for five days until the hospital discharged him with new medication.
30. On 22 April, various prison and healthcare staff held a multi disciplinary team meeting to discuss Mr Shah's continued care. They arranged for a nurse to discuss Mr Shah's wishes for resuscitation with him, a discussion of timeframe for end of life care with a GP and formulation of a Continuing Health Care needs plan. An Occupational Therapy visit was to be arranged and a prison manager was to look into Mr Shah's faith needs and their impact on funeral arrangements.
31. Staff closely monitored him. He seemed to be forgetting to apply his oxygen apparatus or take his inhalers. He became less responsive and, on 3 May, he was sent to hospital.
32. The prison released Mr Shah on unaccompanied temporary licence the next day.
33. Healthcare staff stayed in touch with the hospital who advised that they had given him intravenous antibiotics and did not expect to discharge him soon. He did not recover and died at 8.14am on 7 May 2016.

Contact with Mr Shah's family

34. On 4 May, a member of prison staff informed the family that Mr Shah was in hospital. On 7 May, the prison appointed a family liaison officer (FLO). The FLO

and a prison manager went to the hospital that day to meet family members. The FLO kept in touch with them to offer ongoing support and assistance.

35. Mr Shah's funeral was held on 13 May 2016, and the FLO and a member of the chaplaincy attended. The prison contributed to the costs of the funeral in line with national policy.

Support for prisoners and staff

36. The prison posted notices informing other prisoners of Mr Shah's death, and offering support. Staff did not review all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Shah's death as none of the prisoners who were being managed under suicide and self harm procedures at the time knew Mr Shah. A hot debrief was not held as no staff were with Mr Shah when he died (he had been released on an unaccompanied temporary licence).

Post-mortem report

37. The post-mortem report detailed the cause of death as bronchopneumonia caused by COPD. Ischaemic heart disease, atrial fibrillation, systemic hypertension, chronic kidney disease, diabetes, monoclonal gammopathy of uncertain significance also contributed to his death.

Findings

Clinical care

38. The clinical reviewer found that the care Mr Shah received for his COPD and his other illnesses was equivalent to that he could have expected to receive in the community. Staff always appropriately referred him and arranged treatments.
39. There was a significant delay in Mr Shah being assessed for home oxygen therapy. A prison GP at HMP Stocken had made a referral in January 2015, before Mr Shah moved to Sudbury. He had arranged for Mr Shah to remain under the care of a hospital in February 2015, but then in March the hospital discharged Mr Shah from their care. Sudbury tried to refer him back into the same hospital's care in June, but were unable to do so. Another hospital was approached in August 2015 to organise an oxygen assessment. This eventually took place one year after the first referral for oxygen, in January 2016. From this time, he received oxygen therapy.
40. The clinical reviewer noted that the first hospital was slow to respond the original referral and later the other hospital was slow to respond to the new referral. HMP Sudbury could have responded more quickly to the first hospital's rejection. This did not, however, have an impact on Mr Shah's death so we have not made a recommendation but highlight it as a point of learning for Sudbury.

Support for prisoners and staff

41. PSI 64/2011 'Management of prisoners at risk of harm to self, to others and from others' stipulates that prisoners subject to suicide and self harm management should be reviewed after a death in custody: 'Appropriate care and support must be offered to the cell-mate and any other prisoners directly affected by the death, including all those on open ACCT documents'.
42. The prison has told us that staff did not review any of the prisoners on an ACCT at the time of Mr Shah's death because none of them knew him or were on his unit. However, staff cannot be certain who knows who, and they should not assume that bad news (even about an apparent stranger) might not trigger a detrimental response in a prisoner who is emotionally vulnerable.

The Governor should ensure that following a death in custody staff review all prisoners on an ACCT.

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